



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

CITY OF BEAUMONT EMS  
PO BOX 3827  
BEAUMONT TX 77704-3827

#### **Respondent Name**

TEXAS MUTUAL INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 54

#### **MFDR Tracking Number**

M4-12-2814-01

#### **MFDR Date Received**

MAY 3, 2012

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We mailed a claim to [Claimant] insurance Member's Health on 12/23/2008 with no response until we called about the claim on 08/03/2009 and that's when we were informed that [Claimant] health insurance had terminated in 11/01/2006. We then invoiced [Claimant] on 08/04/2009, 09/03/2009 and 10/05/2009 with no response. We sent [Claimant] another invoice on 03/15/2010 with no response. We tried sending [Claimant] a time pay agreement on 04/14/2010 with no response. On 5/13/2010 [Claimant] was sent to review for collection. On 5/21/2010 [Claimant] was sent to collections. [Claimant] called our office on 2/27/12 to inform us this was a workers comp and could we mail him an invoice also, we mailed a claim on a HCFA to Texas Mutual on 2/28/12. On 3/30/12 we received a Tx Mutual EOB denial dated 3/27/12 past filing deadline."

**Amount in Dispute:** \$630.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The DWC MDR date stamp on the requestor's DWC-60 packet is 5/3/12, a date greater than one year from 12/17/08. Therefore, the requestor has waived its right to medical fee dispute resolution and DWC MDR has no jurisdiction to proceed with an administrative review of this fee dispute."

**Response Submitted by:** Texas Mutual Insurance Co.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
12/17/2008	HCPCS Codes A0425 and A0427	\$630.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- CAC-29-The time limit for filing has expired.
- 731-Per 133.20 provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the service for services on or after 9/1/05.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724-No additional payment after a reconsideration of services.

**Issue**

1. Did the requestor waive the right to medical fee dispute resolution?

**Findings**

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is December 17, 2008. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on May 3, 2012. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

**Conclusion**

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

**Authorized Signature**

_____ Signature	_____ Medical Fee Dispute Resolution Officer	10/3/2013 _____ Date
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***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**